

IN THE SENATE

SENATE BILL NO. 1010

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO MEDICAL ASSISTANCE SERVICES; AMENDING SECTION 56-255, IDAHO CODE, TO REVISE PROVISIONS OF BEHAVIORAL HEALTH SERVICES FOR MEDICAID PARTICIPANTS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-255, Idaho Code, be, and the same is hereby amended to read as follows:

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED. (1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary within the appropriations provided by law and in accordance with federal law and regulation, Idaho law and department rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age adults with no special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found; and

(c) Cost-sharing required of participants. Participants in the low-income children and working-age adult group are subject to the following premium payments, as stated in department rules:

(i) Participants with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guideline are not required to pay premiums; and

(ii) Participants with family incomes above one hundred thirty-three percent (133%) of the federal poverty guideline will be required to pay premiums in accordance with department rule.

(3) Specific health benefits for persons with disabilities or special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found;

(c) Case management services as defined in accordance with section 1905(a)(19) or section 1915(g) of the social security act; and

1 ~~(d) Mental health services delivered by providers that meet national~~
 2 ~~accreditation standards, including:~~

3 ~~(i) Inpatient psychiatric facility services whether in a hospi-~~
 4 ~~tal, or for persons under age twenty-two (22) years in a freestand-~~
 5 ~~ing psychiatric facility, as permitted by federal law, in excess~~
 6 ~~of those limits in department rules on inpatient psychiatric fa-~~
 7 ~~cility services provided under subsection (5) of this section;~~

8 ~~(ii) Outpatient mental health services in excess of those limits~~
 9 ~~in department rules on outpatient mental health services provided~~
 10 ~~under subsection (5) of this section; and~~

11 ~~(iii) Psychosocial rehabilitation for reduction of mental dis-~~
 12 ~~ability for children under the age of eighteen (18) years with a~~
 13 ~~serious emotional disturbance (SED). Individuals age eighteen~~
 14 ~~(18) years to age twenty-one (21) years with severe and persistent~~
 15 ~~mental illness shall have access to benefits up to a weekly cap of~~
 16 ~~five (5) hours while adults over the age of twenty-one (21) years~~
 17 ~~with severe and persistent mental illness shall have access to~~
 18 ~~benefits up to a weekly cap of four (4) hours;~~

19 ~~(e) Long-term care services, including:~~

20 ~~(i) Nursing facility services, other than services in an institu-~~
 21 ~~tion for mental diseases, subject to participant cost-sharing;~~

22 ~~(ii) Home-based and community-based services, subject to federal~~
 23 ~~approval, provided to individuals who require nursing facility~~
 24 ~~level of care who, without home-based and community-based ser-~~
 25 ~~vices, would require institutionalization. These services will~~
 26 ~~include community supports, including options for self-determi-~~
 27 ~~nation or family-directed, which will enable individuals to have~~
 28 ~~greater freedom to manage their own care within the determined~~
 29 ~~budget as defined by department rule; and~~

30 ~~(iii) Personal care services in a participant's home, prescribed~~
 31 ~~in accordance with a plan of treatment and provided by a qualified~~
 32 ~~person under supervision of a registered nurse;~~

33 ~~(f) Services for persons with developmental disabilities, including:~~

34 ~~(i) Intermediate care facility services, other than such ser-~~
 35 ~~vices in an institution for mental diseases, for persons deter-~~
 36 ~~mined in accordance with section 1902(a) (31) of the social secu-~~
 37 ~~rity act to be in need of such care, including such services in a~~
 38 ~~public institution, or distinct part thereof, for persons with in-~~
 39 ~~tellectual disabilities or persons with related conditions;~~

40 ~~(ii) Home-based and community-based services, subject to federal~~
 41 ~~approval, provided to individuals who require an intermediate~~
 42 ~~care facility for people with intellectual disabilities (ICF/ID)~~
 43 ~~level of care who, without home-based and community-based ser-~~
 44 ~~vices, would require institutionalization. These services will~~
 45 ~~include community supports, including options for self-determi-~~
 46 ~~nation or family-directed, which will enable individuals to have~~
 47 ~~greater freedom to manage their own care within the determined~~
 48 ~~budget as defined by department rule. The department shall re-~~
 49 ~~spond to requests for budget modifications only when health and~~

1 safety issues are identified and meet the criteria as defined in
 2 department rule; and
 3 (iii) Developmental disability services for children and adults
 4 shall be available based on need through state plan services or
 5 waiver services as described in department rule. The department
 6 shall develop a blended rate covering both individual and group
 7 developmental therapy services;
 8 (~~gf~~) Home health services, including:
 9 (i) Intermittent or part-time nursing services provided by a home
 10 health agency or by a registered nurse when no home health agency
 11 exists in the area;
 12 (ii) Home health aide services provided by a home health agency;
 13 and
 14 (iii) Physical therapy, occupational therapy or speech pathology
 15 and audiology services provided by a home health agency or medical
 16 rehabilitation facility;
 17 (~~hg~~) Hospice care in accordance with section 1905(o) of the social se-
 18 curity act;
 19 (~~ih~~) Specialized medical equipment and supplies;
 20 (~~ji~~) Medicare cost-sharing, including:
 21 (i) Medicare cost-sharing for qualified medicare beneficiaries
 22 described in section 1905(p) of the social security act;
 23 (ii) Medicare part A premiums for qualified disabled and working
 24 individuals described in section 1902(a) (10) (E) (ii) of the social
 25 security act;
 26 (iii) Medicare part B premiums for specified low-income medicare
 27 beneficiaries described in section 1902(a) (10) (E) (iii) of the so-
 28 cial security act; and
 29 (iv) Medicare part B premiums for qualifying individuals de-
 30 scribed in section 1902(a) (10) (E) (iv) and subject to section 1933
 31 of the social security act; and
 32 (~~kj~~) Nonemergency medical transportation.
 33 (4) Specific health benefits for persons over twenty-one (21) years of
 34 age who have medicare and medicaid coverage include:
 35 (a) All services described in subsection (5) of this section, other
 36 than if provided under the federal medicare program;
 37 (b) All services described in subsection (3) of this section, other
 38 than if provided under the federal medicare program;
 39 (c) Other services that supplement medicare coverage; and
 40 (d) Nonemergency medical transportation.
 41 (5) Benefits for all medicaid participants, unless specifically lim-
 42 ited in subsection (2), (3) or (4) of this section, include the following:
 43 (a) Health care coverage including, but not limited to, basic inpatient
 44 and outpatient medical services, and including:
 45 (i) Physicians' services, whether furnished in the office, the
 46 patient's home, a hospital, a nursing facility or elsewhere;
 47 (ii) Services provided by a physician or other licensed practi-
 48 tioner to prevent disease, disability and other health conditions
 49 or their progressions, to prolong life, or to promote physical or
 50 mental health; and

- 1 (iii) Hospital care, including:
 - 2 1. Inpatient hospital services other than those services
 - 3 provided in an institution for mental diseases;
 - 4 2. Outpatient hospital services; and
 - 5 3. Emergency hospital services;
- 6 (iv) Laboratory and x-ray services;
- 7 (v) Prescribed drugs;
- 8 (vi) Family planning services and supplies for individuals of
- 9 child-bearing age;
- 10 (vii) Certified pediatric or family nurse practitioners' ser-
- 11 vices;
- 12 (viii) Emergency medical transportation;
- 13 (ix) Mental Behavioral health services, including:
 - 14 1. Outpatient mental behavioral health services that are
 - 15 appropriate, within limits stated in department rules
 - 16 delivered by providers that meet national accreditation
 - 17 standards and may include community-based rehabilitation
 - 18 services and case management; and
 - 19 2. Inpatient psychiatric facility services within limits
 - 20 stated in department rules whether in a hospital, or for per-
 - 21 sons under the age of twenty-two (22) years in a freestanding
 - 22 psychiatric facility as permitted by federal law;
- 23 (x) Medical supplies, equipment, and appliances suitable for use
- 24 in the home;
- 25 (xi) Physical therapy and speech therapies combined to align with
- 26 the annual medicare caps; and
- 27 (xii) Occupational therapy to align with the annual medicare cap;
- 28 (b) Primary care medical homes;
- 29 (c) Dental services. Children shall have access to prevention, diag-
- 30 nosis and treatment services as defined in federal law. Adult coverage
- 31 shall be limited to medically necessary oral surgery and palliative
- 32 services and associated diagnostic services. Select covered benefits
- 33 include: exams, radiographs, periodontal, oral and maxillofacial
- 34 surgery and adjunctive general services as defined in department rule.
- 35 Pregnant women, participants on the aged and disabled waiver and the
- 36 developmental disability waiver shall have access to dental services
- 37 that reflect evidence-based practice;
- 38 (d) Medical care and any other type of remedial care recognized under
- 39 Idaho law, furnished by licensed practitioners within the scope of
- 40 their practice as defined by Idaho law, including:
 - 41 (i) Podiatrists' services based on chronic care criteria as de-
 - 42 fined in department rule;
 - 43 (ii) Optometrists' services based on chronic care criteria as de-
 - 44 fined in department rule;
 - 45 (iii) Chiropractors' services shall be limited to six (6) visits
 - 46 per year; and
 - 47 (iv) Other practitioners' services, in accordance with depart-
 - 48 ment rules;
- 49 (e) Services for individuals with speech, hearing and language disor-
- 50 ders as defined in department rule;

1 (f) Eyeglasses prescribed by a physician skilled in diseases of the eye
2 or by an optometrist;

3 (g) Services provided by essential providers, including:

4 (i) Rural health clinic services and other ambulatory services
5 furnished by a rural health clinic in accordance with section
6 1905(1) (1) of the social security act;

7 (ii) Federally qualified health center (FQHC) services and other
8 ambulatory services that are covered under the plan and furnished
9 by an FQHC in accordance with section 1905(1) (2) of the social se-
10 curity act;

11 (iii) Indian health services;

12 (iv) District health departments; and

13 (v) The family medicine residency of Idaho and the Idaho state
14 university family medicine residency; and

15 (h) Physician, hospital or other services deemed experimental are ex-
16 cluded from coverage. The director may allow coverage of procedures or
17 services deemed investigational if the procedures or services are as
18 cost-effective as traditional, standard treatments.